The following services are partially exempt from copayment:

1. Prescriptions for legend drugs beyond a total of $5.00 copayment per calendar month if the recipient uses a single pharmacist as their sole provider of prescription drugs.
2. Outpatient psychotherapy services over 15 hours or $500.00 per equivalent care, (whichever comes first) per recipient per calendar year. This equates to a maximum of $30.00 copayment per recipient per calendar year.
3. Occupational, physical or speech therapy services over 30 hours or $1,500.00 of equivalent care (whichever comes first), per therapy type, per recipient, per calendar year. This equates to a maximum of $60.00 copayment per therapy type, per recipient, per calendar year.
4. Physician, podiatrist and nurse practitioner visits, laboratory, radiology, diagnostic tests, rural health clinic visits, surgery over $30.00 per recipient per provider, per recipient, per calendar year.
5. Inpatient hospital and inpatient stays in institutions (hospitals) for mental disease services beyond $75.00 per stay.

The following recipient groups are exempt from copayments by both Federal and State law:

1. Persons under 18 years of age.
2. Nursing home residents.
3. Persons enrolled in health maintenance organizations (HMOs).

The following services are exempt from copayment by Federal or State law as noted:

Services Exempt by Federal and State Law

- Family Planning Services and Supplies
- Emergency Services
- Services provided to pregnant women, if the service is related to the pregnancy or to the conditions which may complicate the pregnancy.

Services Exempt by State Policy Only

- Home Health Services
- Transportation by a Specialized Medical Vehicle or Transportation Provided or Arranged by a County Department of Social Services.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Wisconsin

D. The procedures for implementing and enforcing the exclusions from cost sharing contained in 42 CFR 447.53(b) are described below:

The automated payment system edits billings for services excluded from cost-sharing. These services are paid at normal rates, while services requiring cost-sharing have the required amount deducted prior to payment.

E. Cumulative maximums on charges:

☐ State policy does not provide for cumulative maximums.

☒ Cumulative maximums have been established as described below:

See attached information.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Wisconsin

B. The method used to collect cost sharing charges for categorically needy individuals:

☒ Providers are responsible for collecting the cost sharing charges from individuals.

☐ The agency reimburses providers the full Medicaid rate for services and collects the cost sharing charges from individuals.

C. The basis for determining whether an individual is unable to pay the charge, and the means by which such an individual is identified to providers, is described below:

Providers must request copayments from recipients for those services requiring copayment; the program's provider bulletins alert them to this responsibility and inform them that service cannot be refused because an individual is unable to pay the required amount. A provider may determine an individual's inability to make payment based on the individual's assertion to that effect, providing there is no evidence to the contrary. Recipients have been notified through recipient newsletters and, upon initial application for eligibility, the Eligibility and Benefits pamphlet.